

This brief is the second in a series of four on the future of children's health in California. This report in particular identifies the current and potential future challenges to pediatric patient care, as well as special populations that should be considered when analyzing child health policy.

Patient Care Challenges

Several challenges to pediatric patient care will remain after the implementation of the Affordable Care Act (ACA). A sizeable population of children will continue to be uninsured, some who are ineligible for full scope Medi-Cal (California's Medicaid program) and Covered California (California's health insurance marketplace) due to immigration status, and some who are eligible, but are not enrolled. Some counties will continue to be responsible for services to remaining uninsured kids, but many others will not. California lawmakers will need to consider the extent of the need for smaller state-run programs when coverage is available through Medi-Cal and Covered California and if those funds can be better utilized elsewhere in the budget. Finally, when imagining an integrated health care system for children post-ACA, the special circumstances of specific populations of children and families, such as immigrants and children with special health care needs, should be given special consideration, as to prevent marginalization or decreased access.

Remaining Uninsured Children

In California, an estimated 11% of children, totaling 1.04 million, are uninsured for part or all of the year.¹ Estimates of how many children will remain uninsured post ACA implementation vary, due to different assumptions about the success of the implementation of the ACA, the extent of outreach, and limited data on the undocumented immigrant population. There are three categories of uninsured children: those who qualify for Medi-Cal but are not enrolled, those who qualify for Covered California but are not enrolled, and undocumented children who are ineligible for either program.

Of California's currently uninsured children, approximately 76% are eligible for Medi-Cal (including Healthy Families), based on household incomes below 250% FPL.² Of the 267,655 uninsured children who are ineligible for Medi-Cal, 144,000 (13% of uninsured kids) will be eligible for subsidies under the Covered California health insurance exchange in 2014, while 95,000 (9% of uninsured kids) will not be eligible for subsidies due to household incomes greater than 400% FPL. While these figures seem promising for extending coverage to all children in California, they do not consider factors like immigration status and actual likelihood to enroll.

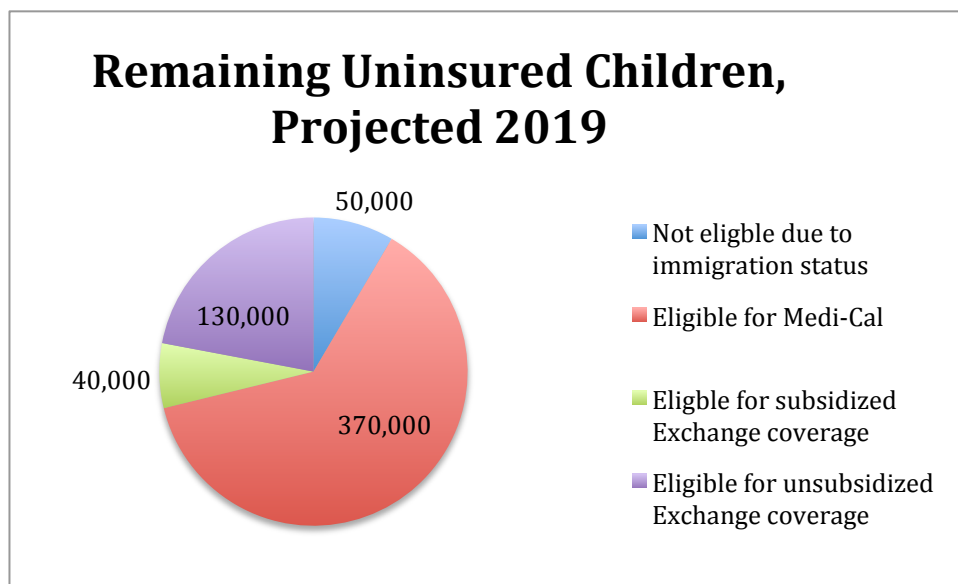
The California Simulation of Insurance Markets model estimates that by 2019, 72,000-140,000 previously eligible but unenrolled children will enroll in Medi-Cal, while 447,000-515,000 eligible kids will fail to take up coverage.³ However this is based on the assumption that only

¹ California Health Interview Survey (2009). Any time during past year without insurance (under 65

² Michael Cousineau et al (2012). *Covering Kids: Children's Health Insurance in California*. California HealthCare Foundation.

³ The failure to take up coverage figure includes children who have employer sponsored or privately purchased coverage, thus it is an overestimate of the uninsured. It does not include children who are

10% (base scenario) to 40% (enhanced scenario) of those eligible will enroll.⁴ An additional 50,000 will remain uninsured despite being eligible for subsidies in Covered California, along with 130,000 children eligible for unsubsidized Exchange coverage. Based on these estimates, there will be 490,000–600,000 children,⁵ contingent upon the extent of outreach, who remain uninsured despite eligibility. The Medi-Cal eligible but unenrolled children can enroll in the program at any time, however Covered California eligible children must wait until open enrollment periods to purchase coverage.



Source: Laurel Lucia et al, *After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?* UC Berkeley Center for Labor Research and Education, UCLA Center for Health Policy Research (September 2012).

Special Challenges in Payer and Provider Counties

Remaining uninsured children will continue to rely upon community clinics and the county safety net for care; thus, it will be important to maintain funding for these institutions. However, the services available to the remaining uninsured vary widely by county and each county’s extent of commitment to serving the uninsured. Currently, 24 counties have Medically Indigent Services Programs (MISP), with half of those counties operating as “providers,” which operate public hospitals and clinics, and the remaining half of counties are divided between “payer” counties that contract with private providers and “hybrid” counties that both operate their own public clinics and contract privately. The remaining counties have County Medical Services Programs (CMSP), which do not cover children. Eligibility for MISPs based on age, income, and immigration status, as well as the services offered, vary significantly, although generally provider counties offer coverage to broader groups of people. Most counties do not

eligible for CHIP. Gerald F. Kominski et al (2012). *Health Insurance Coverage in California under the Affordable Care Act, Revision of the March 22, 2012 Presentation to the California Health Benefit Exchange Board*. UC Berkeley Center for Labor Research and Education, UCLA Center for Health Policy Research.

⁴ Laurel Lucia et al (2012). *After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?* UC Berkeley Center for Labor Research and Education, UCLA Center for Health Policy Research.

⁵ Ibid.

cover children, and if they do, services may be limited to public clinics.

Partial funding for these programs is available through an agreement with the State government; however, considering that the ACA will extend eligibility to a portion of the medically indigent, the State plans to reallocate some of this funding towards increasing Temporary Assistance to Needy Families (TANF) grants for low-income children. How this funding is allocated will determine the future of county medically indigent programs; some counties may opt to maintain eligibility for the remaining uninsured, while other programs may be discontinued or condensed when their patient population becomes Medi-Cal eligible.

As a result of the Medicaid Expansion and the creation of Covered California, some counties now have a significantly reduced responsibility or even no responsibility to care for those they define as medically indigent. A payer county that does not cover indigent care for individuals above 133% of the federal poverty level or for undocumented residents could have no remaining indigent care costs, as those previously served will all be eligible for Medi-Cal. The future of county indigent programs is unclear, but will depend upon state funding decisions and county preferences.

Coordination of Overlapping Programs and Services

The Affordable Care Act expands Medicaid eligibility and the extent of coverage, providing some services currently offered through other programs. The state has already addressed the potential overlap in coverage for low-income children by absorbing Healthy Families, California's Children's Health Insurance Program, into Medi-Cal.

The relevance and need of some of the smaller programs discussed is questionable post-ACA implementation. For example, the Child Health and Disability Program (CHDP) covers preventative services and health assessments for children up to 200% of the federal poverty level (FPL), however all children (with the exception of the undocumented) will be eligible for no-cost or low-cost (\$13 per month per child) Medi-Cal up to 250% FPL.

Many pregnant women and infants between 200-300% FPL will qualify for subsidized Exchange plans and may not need Access for Infants and Mothers (AIM) coverage for prenatal and postpartum care, given that all health plans must cover maternity and newborn care.

Healthy Families is California's Children's Health Insurance Program (CHIP) has been absorbed by Medi-Cal. Its 863,000 members, who were above the previous Medi-Cal income threshold, transitioned into Medi-Cal managed care plans in phases in 2013.

Additionally, while eligibility for Medi-Cal and Covered California will be assessed through the California Healthcare Eligibility, Enrollment, and Retention system (CalHEERS), the application process for some of the other limited coverage programs will remain separate (although CalHEERS will send application data to the appropriate systems).⁶

In the interest of budget savings, care coordination, and maximizing the number of insured children, the State will likely consider modifying, condensing, or merging some coverage programs. Folding programs into Medi-Cal, Covered California, or a new comprehensive benefit

⁶ Covered California. *California Healthcare Eligibility Enrollment, and Retention System (CalHEERS) Requirements Process*. Retrieved from <http://www.healthexchange.ca.gov/Stakeholders/Documents/CalHEERS%20Requirement%20Process%20and%20Requirements%20Document.pdf>

program would likely capture more individuals due to more effective outreach; awareness of Medi-Cal and the Exchange will be much higher than the various smaller, limited scope programs. Care continuity would also be superior, as individuals could stay with providers like the county and community safety net clinics or private physicians, versus being switched into plans with varying networks.

There are, however, disadvantages to consolidating programs, most notably eliminating the few available sources of coverage to undocumented immigrants. Additionally, condensing a program like California Children's Services (CCS), which provides specialty care to children with complex conditions, could leave particularly vulnerable populations in the care of less qualified provider networks and less comprehensive benefit packages, while the elimination of Family Planning, Access, Care, and Treatment (Family PACT), which covers reproductive and sexual health services, could discourage teenagers from seeking family planning services covered by their insurance due to confidentiality issues.

Special Populations

Children and families will be affected by the ACA in different ways. Some groups, like foster children, will benefit from extended Medi-Cal eligibility. Other families will have to navigate multiple unfamiliar insurance and health care systems. Some populations, such as children with special health care needs, are especially vulnerable and may not be appropriately served under the current system. These groups should be given special consideration when proposing changes to Medi-Cal, Covered California, and the health care system as a whole in an effort to insure 100% of children in California and to meet their most important health needs. These are vital investments in our state's future.

Mixed Eligibility Families

The creation of Bridge Plans, which allow household members of children in Medi-Cal to enroll in Medi-Cal managed plans despite incomes over the Medi-Cal income threshold for adults, will limit the number of families with different plans and provider networks due to children enrolled in Medi-Cal and parents in the Exchange.⁷ Yet there will still be some families with mixed eligibility and uptake, such as families with non-custodial grandparents living in the home,⁸ resulting in parents/other family members and children in different plans. Household members enrolling in multiple plans is not ideal, as this creates two or more sets of provider networks to coordinate, rules and guidelines to comprehend, and cost-sharing provisions to budget for. For example, if one parent receives employer-sponsored insurance while the children are enrolled in Exchange plans, the family has two different deductibles, out-of-pocket maximums, even local in-network hospitals. Differences in enrollment periods and processes could easily confuse families and even prevent coverage and/or care. These differences create challenges for families in planning and budgeting for care.

⁷ Bridge plans were not offered during open enrollment in 2013-14 and are still pending contract negotiations.

⁸ Under Medicaid rules, the eligibility of children is assessed based on the income of those legally responsible for the child (i.e. parents and legal guardians). Under these rules, the income of non-custodial caregivers such as grandparents, is not counted for the child, thus creating scenarios in which the children qualify for Medi-Cal because their counted household income is under 250% FPL, but the other household members are above 250% FPL and thus ineligible for Bridge Plans.

Immigrant Children

Children who are legal residents generally have full access to coverage programs in California. There is no waiting period for Medi-Cal, Exchange coverage, or access to subsidies. Those in the US on temporary visas can access Covered California and subsidies, but Medi-Cal eligibility is dependent on intent to remain in California.⁹

Undocumented immigrant children, however, have limited coverage options. The undocumented are ineligible for full-scope Medi-Cal, but can receive restricted scope in cases of necessary emergency care. Exchange coverage, with or without subsidies, is unavailable to undocumented immigrants. Some undocumented children may be covered through their parents' employer-sponsored plans or may receive services through community clinics or one of the ancillary programs described previously. CCS, CHDP, Family PACT, and AIM only require members to be residents of California, which can be proven without a green card or social security number. It is unclear how many undocumented children these programs currently serve. Some undocumented children have access to locally administered nonprofit programs such as Healthy Kids, CaliforniaKids, and Kaiser Child Health Plan.

Estimates of the size of the undocumented population vary considerably. One study of the impact of the ACA finds that in California, there are 140,000 undocumented immigrant children with household incomes less than 133% of FPL and 30,000 undocumented children between 134-400% of FPL.¹⁰ These children would otherwise be eligible for Medi-Cal or subsidized Exchange coverage based on income; however, the exclusion of undocumented immigrants from the ACA disqualifies them from enrollment. Additionally, the authors project that 40,000 uninsured children who are legal residents or US citizens will not take up coverage in Medi-Cal or Covered California because their undocumented parents are unaware of their child's eligibility.

Undocumented children are a vulnerable population that is likely to remain uninsured. It is estimated that 48.6% of undocumented kids are currently uninsured,¹¹ and considering that the undocumented do not benefit from any of the ACA's coverage expansions, this figure is unlikely to change. UC Berkeley/UCLA estimates that approximately one million people in California will remain uninsured due to citizenship status.¹² Although it is unclear what portion of this population will be children, only approximately 10% of undocumented immigrants in the US are under age 18.¹³ Illegal immigration has declined significantly in the past few years, potentially due to the recession, enhanced border enforcement, and improving economic opportunities in Mexico. Between 2008 and 2010, California's population of unlawfully present immigrants declined by 280,000.¹⁴ If this trend continues, the population of uninsured undocumented children in California could further shrink as currently present undocumented children grow into adults.

The currently proposed immigration reform (S. 744, the Border Security, Economic

⁹ California Department of Health Care Services (2013). *Medi-Cal Handbook, Section 42: California Residency*.

¹⁰ These estimates of the undocumented population vary considerably from Laurel Lucia et al's figures. Ninez Ponce et al (2011). *The Impact of Health Care Reform on California's Children in Immigrant Families*. UCLA Center for Health Policy Research.

¹¹ Ibid.

¹² Op cit. Kominski.

¹³ Pew Research Hispanic Center (2013). *A Nation of Immigrants: A Portrait of the 40 Million, Including 11 Million Unauthorized*.

¹⁴ Johnson, H., & Hill, L. (2011). *At Issue: Illegal Immigration*. Public Policy Institute of California.

Opportunity, and Immigration Modernization Act of 2013) offers a long-term path to citizenship and eligibility for public programs. However, the bill's potential impact on the short-term health coverage of immigrants seeking legal residency is limited. Those who would apply for registered provisional immigrant (RPI) status would have to wait at least 10 years for Medi-Cal eligibility.¹⁵ Individuals would be eligible to purchase insurance coverage through the Exchanges once they obtain RPI status, however they would not be eligible for subsidies until they become legal permanent residents after 10 years of RPI status.¹⁶ Given the average low income of undocumented households,¹⁷ few could afford unsubsidized coverage through the Exchange. New RPIs would continue to rely upon state and local programs, such as unmatched Low Income Health Programs, CCS, CHDP, AIM, and Family PACT for coverage of specific services in the absence of Medi-Cal benefits.

Children in Foster Care

The 63,000 children in foster care in California are automatically eligible for Medi-Cal.¹⁸ Former foster youth remain eligible for Medi-Cal until age 21, with the Medicaid Expansion extending eligibility until age 26, regardless of income.¹⁹ Eligibility decisions for foster youth are often expedited to provide quick access to services.²⁰ Foster children are less likely to receive services through the Medi-Cal managed care system than other Medi-Cal populations, as their enrollment in a managed care plan is voluntary.^{21, 22} The Health Care Program for Children in Foster Care provides care coordination, in addition to normal social work services through foster care, for these children. As of 2013, county departments of mental health must offer additional benefits, including extensive care coordination and home-based services, to foster children.²³

Children in the Juvenile Justice System

Children in the juvenile justice system, 225,000 annually, have extensive health needs, particularly mental health needs, that can go unmet while incarcerated and upon their release.²⁴ While many children in the juvenile justice system qualify for Medi-Cal, federal funds cannot be used to cover prison or jail health services for convicted individuals. The counties assume financial responsibility for healthcare for county jail inmates and the State for state prison inmates. When Medi-Cal members are booked into a correctional facility, they are disenrolled

¹⁵ S 744 Sec. 2101.

¹⁶ Ibid.

¹⁷ Passel, J. & D'Vera, C. (2009). *A Portrait of Unauthorized Immigrants in the United States*, Pew Research Hispanic Center.

¹⁸ Arnquist, S., & Harbage, P. (2013). *A Complex Case: Public Mental Health Delivery and Financing in California*. California HealthCare Foundation.

¹⁹ Individuals in foster care in California on their 18th birthday are automatically enrolled in Medi-Cal for continuation benefits until age 26. Welfare and Institutions Code §14005.28

²⁰ The Health Consumer Alliance (2006). *The Health Care Rights of Children in Foster Care*.

²¹ Sphere Institute (2003). *Utilization of Medi-Cal Services by Current and Former Foster Care Children*.

²² Medi-Cal Managed Care. Health Care Options Frequently Asked Questions. Retrieved from: http://www.healthcareoptions.dhcs.ca.gov/HCO_CSP/HCO_Program/Frequently_Asked_Questions.aspx

²³ Op cit. Arnquist.

²⁴ Bussiere, A., & Burrell, S. (2006). *Improving Access to Medi-Cal for Youth in the Juvenile Justice System*. Youth Law Center.

²⁵ Op cit. Arnquist.

from Medi-Cal, and must reapply upon release to be covered.²⁶ This creates challenges to continuous coverage, continuity of care, and timely treatment.

County staff who work with this population have argued that the paperwork associated with disenrollment and reenrollment is particularly burdensome and the overall process results in no coverage post release. While in some counties staff will help children reapply for Medi-Cal upon release, the youth still must go through the entire application and eligibility determination process again and wait up to 45 days for a decision from the County Social Services offices. The Youth Law Center recommends that the State suspend instead of terminate Medi-Cal coverage for children while they are incarcerated, so that services can be obtained immediately upon release.

Children with Disabilities and Chronic Health Conditions

Children with disabilities and/or chronic health conditions are a particularly vulnerable population in need of comprehensive, specialized care. Medi-Cal currently carves out benefits for many children with complex conditions, making treatment for the chronic conditions the responsibility of California Children's Services, while primary care still falls under managed care. Medi-Cal managed care plans may not have the highly specialized providers necessary to treat complicated and rare conditions.²⁷ During the 2011-12 transition of seniors and persons with disabilities to managed care, various managed care plans and providers reported unpreparedness and being overwhelmed when assigned patients with complex care needs. Due to the challenges in recruiting both specialists and highly skilled primary care providers, individuals with disabilities experienced fragmented care and were even sent to emergency rooms to seek treatment.²⁸ Managed care plans have also expressed concern with their ability to take on the extensive costs of care for children affected by rare or complex conditions.²⁹ Yet the current system of carving-out specialty services through CCS interferes with holistic, whole-person care because provider networks differ between CCS and managed plans and there can be confusion about who pays for which services.³⁰ The CCS program is expected to remain intact in its current format while other service provision models are explored through pilots. Without legislative intervention, Medi-Cal managed plans cannot offer any CCS covered services as managed care benefits until 2016.^{31,32}

Maryland has developed an interesting model for caring for individuals with complex conditions. While Maryland's Medicaid system is managed care based, a small fee-for-service program exists for high-risk, high-cost patients called the "Rare and Expensive Case Management Program" (REM). This program offers extensive case management, including face-to-face contact and status reports for each patient at least every 90 days, to approximately 4,000 patients with severe conditions.^{33, 34} REM differs from CCS in that its enrollees and all of the

²⁶ Ibid.

²⁷ Health Management Associates (2009). *Considerations for Redesign of the California Children's Services (CCS) Program*.

²⁸ Kaiser Family Foundation (2013). *Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California*. The Kaiser Commission on Medicaid and the Uninsured.

²⁹ Ibid.

³⁰ Op cit. Health Management Associates.

³¹ Welfare and Institutions Code Section 14094.3

³² County Organized Health Systems can provide these services however.

³³ Sanjay K. Pandey et al. *An Assessment of Maryland Medicaid's Rare and Expensive Case Management Program*. Eval Health Prof 2000 23:457.

³⁴ Maryland Department of Health and Mental Hygiene. Rare and Expensive Case Management RFP. Questions, January 22, 2013.

services they require, including primary care, are totally exempt from managed care, thus services are coordinated in a comprehensive manner, and the case management is designed to be much more extensive than what CCS offers. An early study of the program showed that people with complex diseases incurred significantly lower inpatient costs (nearly \$1,000 less per patient per month) when provided with case management.³⁵

Thank you to the Lucile Packard Foundation for Children’s Health for funding this project.



³⁵ Op cit. Pandey.